		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036335

Facility Name: SPARTA TERRACE

Address: 1501 MELMAR DRIVE (Number) SPARTA (City) 62886 (Zip Code)

County: RANDOLPH

Telephone Number: 618-443-2122 **Fax #** 618-443-2339

IDPA ID Number: 363234108003

Date of Initial License for Current Owners: 06/01/90

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501©(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROB KEIME **Telephone Number:** 309-685-0595 EXT. 304

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 06/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) VINCENT EVERSON
(Title) PRESIDENT & CEO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,055			5,055	13
14	TOTALS	5,055			5,055	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.32%

D. How many bed-hold days during this year were paid by Public Aid?
175 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/04 Fiscal Year: 06/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SPARTA TERRACE # 0036335 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	26,322	1,555	1,685	29,562		29,562	600	30,162			1
2	Food Purchase		22,029		22,029		22,029		22,029			2
3	Housekeeping		1,114		1,114		1,114		1,114			3
4	Laundry		1,839		1,839		1,839		1,839			4
5	Heat and Other Utilities			9,310	9,310		9,310	242	9,552			5
6	Maintenance	8,111		7,284	15,395		15,395	(284)	15,111			6
7	Other (specify):*											7
8	**TOTAL General Services**	34,433	26,537	18,279	79,249		79,249	558	79,807			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	150,055	2,872	4,550	157,477		157,477	400	157,877			10
10a	Therapy			879	879		879		879			10a
11	Activities			1,186	1,186		1,186		1,186			11
12	Social Services			1,970	1,970		1,970		1,970			12
13	Nurse Aide Training	1,958		50	2,008		2,008		2,008			13
14	Program Transportation			2,307	2,307		2,307		2,307			14
15	Other (specify):* DENTAL			3,019	3,019		3,019		3,019			15
16	**TOTAL Health Care and Programs**	152,013	2,872	15,161	170,046		170,046	400	170,446			16
	C. General Administration											
17	Administrative	31,026		52,013	83,039		83,039	(16,094)	66,945			17
18	Directors Fees			1,592	1,592		1,592	1,241	2,833			18
19	Professional Services			5,421	5,421		5,421	1,481	6,902			19
20	Dues, Fees, Subscriptions & Promotions			1,497	1,497		1,497	316	1,813			20
21	Clerical & General Office Expenses		2,735	12,454	15,189		15,189	9	15,198			21
22	Employee Benefits & Payroll Taxes			46,169	46,169		46,169	6,902	53,071			22
23	Inservice Training & Education			4,304	4,304		4,304	1,763	6,067			23
24	Travel and Seminar							147	147			24
25	Other Admin. Staff Transportation			756	756		756	31	787			25
26	Insurance-Prop.Liab.Malpractice			8,645	8,645		8,645	233	8,878			26
27	Other (specify):*											27
28	**TOTAL General Administration**	31,026	2,735	132,851	166,612		166,612	(3,971)	162,641			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	217,472	32,144	166,291	415,907		415,907	(3,013)	412,894			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SPARTA TERRACE #0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			8,494	8,494		8,494	777	9,271			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,947	5,947		5,947	(1,320)	4,627			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			69,255	69,255		69,255	1,307	70,562			34
35	Rent-Equipment & Vehicles							50	50			35
36	Other (specify):*											36
37	**TOTAL Ownership**			83,696	83,696		83,696	814	84,510			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,041	35,041		35,041		35,041			42
43	Other (specify):* NONALLOWABLE			139,208	139,208		139,208	(139,208)				43
44	**TOTAL Special Cost Centers**			174,249	174,249		174,249	(139,208)	35,041			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	217,472	32,144	424,236	673,852		673,852	(141,407)	532,445			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(139,196)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(680)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(21)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(209)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(414)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (140,520)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(887)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (887)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (141,407)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SPARTA TERRACE

ID# 0036335

Report Period Beginning: 07/01/03

Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SPARTA TERRACE # 0036335 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	600	0	0	0	0	0	0	0	0	600	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	242	0	0	0	0	0	0	0	0	242	5
6	Maintenance	(680)	0	396	0	0	0	0	0	0	0	0	(284)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(680)	0	1,238	0	0	0	0	0	0	0	0	558	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	400	0	0	0	0	0	0	0	0	400	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	400	0	0	0	0	0	0	0	0	400	16
	C. General Administration													
17	Administrative	0	0	(16,094)	0	0	0	0	0	0	0	0	(16,094)	17
18	Directors Fees	0	0	1,241	0	0	0	0	0	0	0	0	1,241	18
19	Professional Services	0	0	1,481	0	0	0	0	0	0	0	0	1,481	19
20	Fees, Subscriptions & Promotions	0	(4)	320	0	0	0	0	0	0	0	0	316	20
21	Clerical & General Office Expenses	0	9	0	0	0	0	0	0	0	0	0	9	21
22	Employee Benefits & Payroll Taxes	0	0	6,902	0	0	0	0	0	0	0	0	6,902	22
23	Inservice Training & Education	0	0	1,763	0	0	0	0	0	0	0	0	1,763	23
24	Travel and Seminar	0	0	147	0	0	0	0	0	0	0	0	147	24
25	Other Admin. Staff Transportation	0	0	31	0	0	0	0	0	0	0	0	31	25
26	Insurance-Prop.Liab.Malpractice	0	0	233	0	0	0	0	0	0	0	0	233	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	5	(3,976)	0	0	0	0	0	0	0	0	(3,971)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(680)	5	(2,338)	0	0	0	0	0	0	0	0	(3,013)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SPARTA TERRACE # 0036335 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	777	0	0	0	0	0	0	0	0	777	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(230)	(539)	(551)	0	0	0	0	0	0	0	0	(1,320)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	1,307	0	0	0	0	0	0	0	0	1,307	34
35	Rent-Equipment & Vehicles	0	0	50	0	0	0	0	0	0	0	0	50	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(230)	(539)	1,583	0	0	0	0	0	0	0	0	814	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(139,610)	0	402	0	0	0	0	0	0	0	0	(139,208)	43
44	**TOTAL Special Cost Centers**	(139,610)	0	402	0	0	0	0	0	0	0	0	(139,208)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(140,520)	(534)	(353)	0	0	0	0	0	0	0	0	(141,407)	45

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
RESIDENTIAL CENTERS, INC.	100	SEE ATTACHED RELATED PARTY SCHEDULE		SEE ATTACHED RELATED PARTY SCHEDULE		
SEE ATTACHED SCHEDULA 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	BOARD FEES	$ 1,592	RESIDENTIAL CENTERS	100.00%	$ 1,592	$	1
2	V	19	PROFESSIONAL FEES	5,146	RESIDENTIAL CENTERS	100.00%	5,146		2
3	V	20	LICENSE DUES	3	RESIDENTIAL CENTERS	100.00%	(1)	(4)	3
4	V	21	OFFICE SUPPLIES	3,254	RESIDENTIAL CENTERS	100.00%	3,263	9	4
5	V	22	INSERVICE TRAVEL	106	RESIDENTIAL CENTERS	100.00%	106		5
6	V	32	INTEREST EXPENSE	4,975	RESIDENTIAL CENTERS	100.00%	5,048	73	6
7	V	32	MISCELLANEOUS INCOME		RESIDENTIAL CENTERS	100.00%	(193)	(193)	7
8	V	32	INTEREST INCOME		RESIDENTIAL CENTERS	100.00%	(419)	(419)	8
9	V	43	NONALLOW	12	RESIDENTIAL CENTERS	100.00%	12		9
10	V				RESIDENTIAL CENTERS	100.00%			10
11	V								11
12	V								12
13	V								13
14	Total			$ 15,088			$ 14,554	$ * (534)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE COST	$ 52,013	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO	$ 35,919	$ (16,094)	15
16	V	18	DIRECTORS FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,241	1,241	16
17	V	19	PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,481	1,481	17
18	V	20	DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	320	320	18
19	V	22	EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	6,902	6,902	19
20	V	23	INSERVICE EDUCAQTION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,763	1,763	20
21	V	24	TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	147	147	21
22	V	25	OTHER STAFF TRANSPORTATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	31	31	22
23	V	26	INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	233	233	23
24	V	30	DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	777	777	24
25	V	32	INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	84	84	25
26	V	34	RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,307	1,307	26
27	V	35	EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	50	50	27
28	V	5	UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	242	242	28
29	V	6	MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	396	396	29
30	V	43	NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	402	402	30
31	V	32	INTEREST INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(68)	(68)	31
32	V	32	MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(567)	(567)	32
33	V	1	DIETARY		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	600	600	33
34	V	10	NURSING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	400	400	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 52,013			$ 51,660	$ * (353)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	RONALD SCHROEDER	CHAIRMAN	BOARD MEMBEI	NONE	15,602	3HRS/MTG	2.00	DIR. FEES	$ 398	L18, C8	1
2	SHAWN JEFFERS	VICE CHAIRMAN	BOARD MEMBEI	NONE	14,802	3HRS/MTG	2.00	DIR. FEES	398	L18, C8	2
3	EDWARD CHILDERS	SECRETARY	BOARD MEMBEI	NONE	15,602	3HRS/MTG	2.00	DIR. FEES	398	L18, C8	3
4	ROBERT BAUER	TREASURER	BOARD MEMBEI	NONE	4,402	3HRS/MTG	2.00	DIR. FEES	398	L18, C8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 1,592		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: RESIDENTIAL CENTERS, INC.
Street Address: 2020 W. WAR MEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 616147
Phone Number: (309-685-0595
Fax Number: (309-685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	NUMBER OF BEDS	193	4	$ 19,200	$ 0	16	$ 1,592	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	193	4	62,073	0	16	5,146	2
3	20	LICENSE DUES	NUMBER OF BEDS	193	4	(8)	0	16	(1)	3
4	21	OFFICE SUPPLIES	NUMBER OF BEDS	193	4	39,355	0	16	3,263	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	193	4	1,283	0	16	106	5
6	32	INTEREST EXPENSE	NUMBER OF BEDS	193	4	60,889	0	16	5,048	6
7	32	MISCELLANEOUS INCOME	NUMBER OF BEDS	193	4	(2,328)	0	16	(193)	7
8	32	INTEREST INCOME	NUMBER OF BEDS	193	4	(5,056)	0	16	(419)	8
9	43	NONALLOW	NUMBER OF BEDS	193	4	150	0	16	12	9
10			NUMBER OF BEDS	193	4		0	16	0	10
11			NUMBER OF BEDS	193	4		0	16	0	11
12			NUMBER OF BEDS	193	4		0	16	0	12
13			NUMBER OF BEDS	193	4		0	16	0	13
14			NUMBER OF BEDS	193	4		0	16	0	14
15			NUMBER OF BEDS	193	4		0	16	0	15
16			NUMBER OF BEDS	193	4		0	16	0	16
17			NUMBER OF BEDS	193	4		0	16	0	17
18			NUMBER OF BEDS	193	4		0	16	0	18
19			NUMBER OF BEDS	193	4		0	16	0	19
20			NUMBER OF BEDS	193	4		0	16	0	20
21			NUMBER OF BEDS	193	4		0	16	0	21
22			NUMBER OF BEDS	193	4		0	16	0	22
23			NUMBER OF BEDS	193	4		0	16	0	23
24										24
25	TOTALS					$ 175,558	$		$ 14,554	25

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CENTER FOR RESIDENTIAL MANAGEMENT
Street Address: 2020 W. WAR MEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 616147
Phone Number: (309-685-0595
Fax Number: (309-685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE COST	BEDS	330	18	$ 699,564	$ 574,949	16	$ 33,919	1
2	18	DIRECTORS FEES	BEDS	330	18	25,600		16	1,241	2
3	19	PROFESSIONAL FEES	BEDS	330	18	30,555		16	1,481	3
4	20	DUES, FEES	BEDS	330	18	6,605		16	320	4
5	22	EMPLOYEE BENEFITS	BEDS	330	18	137,341		16	6,659	5
6	23	INSERVICE EDUCAQTION	BEDS	330	18	36,366		16	1,763	6
7	24	TRAVEL SEMINAR	BEDS	330	18	3,032		16	147	7
8	25	OTHER STAFF TRANSPORTATIO	BEDS	330	18	631		16	31	8
9	26	INSURANCE	BEDS	330	18	4,797		16	233	9
10	30	DEPRECIATION	BEDS	330	18	16,031		16	777	10
11	32	INTEREST	BEDS	330	18	1,737		16	84	11
12	34	RENT	BEDS	330	18	26,963		16	1,307	12
13	35	EQUIPMENT RENTAL	BEDS	330	18	1,020		16	50	13
14	5	UTILITIES	BEDS	330	18	5,000		16	242	14
15	6	MAINTENANCE	BEDS	330	18	4,559		16	221	15
16	43	NONALLOWABLE	BEDS	330	18	8,286		16	402	16
17	32	INTEREST INCOME	BEDS	330	18	(1,401)		16	(68)	17
18	32	MISC INCOME	BEDS	330	18	(11,699)		16	(567)	18
19										19
20	17	ADMINISTRATIVE COST	DIRECT				2,000		2,000	20
21	1	DIETARY	DIRECT				600		600	21
22	10	NURSING	DIRECT				400		400	22
23	22	EMPLOYEE BENEFITS	DIRECT						243	23
24	6	MAINTENANCE	DIRECT				175		175	24
25	TOTALS					$ 994,987	$ 578,124		$ 51,660	25

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	EFFINGHAM STATE BANK		X	VEHICLE	$622.29	09/23/03	$ 20,257	$ 15,564	09/30/03	6.6500	$ 907	1
2												2
3												3
4												4
5												5
	Working Capital											
6				ALLOCATED FROM PARENT CO.							5,132	6
7				MISCELLANEOUS INTEREST							125	7
8				OFFSET INTEREST INC/NONALLOWABLE							(1,537)	8
9	TOTAL Facility Related				$622.29		$ 20,257	$ 15,564			$ 4,627	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 20,257	$ 15,564			$ 4,627	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SPARTA TERRACE COUNTY RANDOLPH

FACILITY IDPH LICENSE NUMBER 0036335

CONTACT PERSON REGARDING THIS REPORT ROB KEIME

TELEPHONE 309-685-0595 EXT 304 FAX #: 309-685-8463

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$ N/A	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100 B. General Construction Type: Exterior WOOD WITH SIDINC Frame WOOD Number of Stories ONE

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SECURITY ALARM SYSTEM			1994	2,045	136	15	136		1,432	9
10	CARPET			1995	1,301	87	15	87		824	10
11	REPLACEMENT OF WATER LINE			1995	1,550	103	15	103		904	11
12	ADDITIONAL WATER LINE			1995	1,001	67	15	67		573	12
13	MIXING VALVE			1998	626	42	15	42		272	13
14	CARPET			1998	1,185	79	15	79		487	14
15	BACKFLOW PREVENTION			1998	1,131	76	15	76		422	15
16	PAINT AND CERAMIC TILE			1999	827	55	15	55		303	16
17	SECIND BACKFLOW PREVENTION			1999	1,165	78	15	78		401	17
18	TILE			1999	3,116	208	15	208		952	18
19	SHOWER			1999	1,113	74	15	74		340	19
20	PARKING LOT			2002	2,850	190	15	190		396	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 17,910	$ 1,195		$ 1,195	$	$ 7,306	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 21,446	$ 1,869	$ 1,869	$	5-10 YRS	$ 14,341	71
72	Current Year Purchases	5,957	275	275		5-10 YRS	275	72
73	Fully Depreciated Assets	2,423				5-10 YRS	2,423	73
74	PARENT CO. ALLOC.		777	777				74
75	TOTALS	$ 29,826	$ 2,921	$ 2,921	$		$ 17,039	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT CARE	1996 BUICK CENTURY	2002	$ 4,500	$ 900	$ 900	$	5	$ 2,250	76
77	RESIDENT CARE	2003 CHEVY VAN	2003	25,165	3,775	3,775		5	3,775	77
78	RESIDENT CARE	1998 VAN TRADED IN	2002		480	480		5		78
79										79
80	TOTALS			$ 29,665	$ 5,155	$ 5,155	$		$ 6,025	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 77,401	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,271	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 9,271	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 30,370	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: COMMUNITY LIVING OPTIONS
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		16	06/01/00	$ 69,255	5	5	3
4	Additions							4
5								5
6								6
7	TOTAL		16		$ 69,255 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 06/01/00
    Ending 05/31/05

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	06/30/2005	$ 63,484
13.	06/30//2006	$ 0
14.	06/30//2007	$ 0

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 0 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			50		50
3	Classroom Wages	(a)		653		653
4	Clinical Wages	(b)		1,305		1,305
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 2,008	$	$ 2,008
10	SUM OF line 9, col. 1 and 2	(e)	$ 2,008			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 2,836

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): ER DENTAL SCH. V LINE 39		6			640		6	640	13
14	TOTAL			$		$ 640	$	6	$ 640	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SPARTA TERRACE **#** 0036335 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,511	$	1
2	Cash-Patient Deposits	6,939		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (8,819))	55,117		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,511		6
7	Other Prepaid Expenses	15,961		7
8	Accounts Receivable (owners or related parties)	241,121		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 324,160	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	17,910		15
16	Equipment, at Historical Cost	59,491		16
17	Accumulated Depreciation (book methods)	(30,368)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LOAN FEES	4,582		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 51,615	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 375,775	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 41,187	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,939		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,348		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 60,474	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,564		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 15,564	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 76,038	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 299,737	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 375,775	$	48

***(See instructions.)**

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 263,918	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 263,918	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	35,819	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 35,819	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 299,737	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 567,618	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 567,618	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	139,196	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	2,836	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 142,032	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 709,671	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	79,249	31
32	Health Care	170,046	32
33	General Administration	166,612	33
	B. Capital Expense		
34	Ownership	83,696	34
	C. Ancillary Expense		
35	Special Cost Centers	139,208	35
36	Provider Participation Fee	35,041	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 673,852	40
41	**Income before Income Taxes (line 30 minus line 40)****	35,819	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 35,819	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	140	152	2,660	17.50	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	240	240	1,958	8.16	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,361	2,617	26,322	10.06	15
16	Dishwashers					16
17	Maintenance Workers	886	901	8,111	9.00	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,582	1,627	31,026	19.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	16,614	18,069	147,395	8.16	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,823	23,606	$ 217,472 *	$ 9.21	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	23	$ 1,636		35
36	Medical Director	MONTHLY	1,200		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	550		39
40	Physical Therapy Consultant	3	175		40
41	Occupational Therapy Consultant	3	227		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	477		43
44	Activity Consultant				44
45	Social Service Consultant	42	1,970		45
46	Other(specify)				46
47	PSYCHOLOGICAL	MONTHLY	2,584		47
48					48
49	TOTAL (lines 35 - 48)	78	$ 8,819		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LISA TIPPY	ADMINISTRATOR	0	$ 31,026
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 31,026

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PERSONNEL PLANNERS, INC	U/C CONSULTATION	$ 275
LAWRENCE MANSON	LEGAL	1,645
GARDNER CARTON&DOUGLAS	LEGAL	803
HEINOLD-BANWART	ACCOUNTING	2,657
AMERICAN EXPRESS TB	ACCOUNTING	41
WESTERVELT JOHNSON	LEGAL	102
LAWRENCE MANSON	LEGAL	942
HEINOLD-BANWART	ACCOUNTING	424
JOHN GRABER	TITLE WORK	13
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 6,902

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 3,486
Unemployment Compensation Insurance	4,929
FICA Taxes	17,901
Employee Health Insurance	20,767
Employee Meals	4,525
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE MORAL	1,310
PHYSICALS	153
TOTAL (agree to Schedule V, line 22, col.8)	$ 53,071

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
ILLINOIS HEALTH CARE DUES	864
VEHICLE LICENSE	117
AAMR MEMBERSHIP	155
MES MEMBERSHIP	175
MISCELLANEOUS DUES & FEES	502
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,813

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
PARENT COMPANY ALLOCATION	147
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 147

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SPARTA TERRACE # 0036335 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE ASSOC. $864**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,041**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,525** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **85%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: **HEINOLD - BANWART, LTD.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.